Proposed 2005-07 Policy Initiative

Name of Initiative	Health Insurance Reform
Sponsor	Access Committee
Lead Staff	Craig McLaughlin
Other Committees	Health Disparities, Children's Health and Well-Being
Summary	Convene a discussion about ways to reduce health insurance costs and improve access to insurance and to appropriate health care by consolidating risk pools and providing for a single administrative entity to handle health insurance payments. This could be focused on all people or on children as a way to advance the Governor's goal of covering all kids by 2010.
SHR Strategic Direction	☐ Maintain and improve the public health system ☒ Ensure fair access to critical health services ☒ Improve health outcomes and increase value ☒ Explore ways to reduce health disparities ☐ Improve nutrition and increase physical activity ☐ Reduce tobacco use ☐ Safeguard environments that sustain human health
Governor's Initiatives	☒ Cost Containment ☒ Cover all Kids by 2010 ☐ Healthiest State in the Nation
Possible Partners	Office of the Insurance Commissioner, Health Care Authority, DOH, DSHS, medical professional associations, health advocacy organizations, Washington Health Care Forum
Criteria	☒ Does the issue involve multiple agencies? ☒ Can a measurable difference be made? ☐ Prevalence, severity and availability of interventions ☒ Level of public input/demand ☒ Does it involve the entire state? ☒ Does the Board have statutory authority? ☐ Do the resources exist to deal with the issue? ☒ Does the Board have a potentially unique role?

Problem Statement

The United States health care financing system is based on a mix of state and private insurance. Though largely employment-based since World War II, it has continued to evolve. Today, more than half of health care expenditures are covered by the government in the form of insurance programs, coverage for government employees, or tax subsidies. The rest is paid through a mix of employer-purchased health insurance, coverage purchased individually, or through associations, charity care, and out-of-pocket expenditures.

This creates a large number of payers. It also results in the creation of the huge number of separate risk pools. The original insurance model called for spreading risk across the entire population. This is import because a small number of people with serious illnesses and chronic conditions tend to account for a large share of health care costs. Among Washington State enrollees, for example, 5 percent of the enrollees account for 50 percent of all expenditures. To control costs, maintain profits, and keep their rates competitive, insurers have been increasingly narrowing the populations they serve to focus on low-risk, low-cost individuals (healthy children and young adults). Government programs and high-risk pools are increasingly covering high-cost individuals (the elderly, people with chronic conditions, etc.).

There have been numerous published studies that have found this system to be grossly inefficient. A January 2004 article in the *International Journal of Health Services*, written by researchers at Harvard and Public Citizen, found that health care bureaucracy in the United States cost approximately $400 billion in 2003. Going to a national health insurance model, the authors estimated, could save the country $286 billion a year, which could be used to cover the uninsured ($80 billion), cover seniors' out-of-pocket drug costs ($53 billion), pay for job training and placement for displaced insurance workers, and improve coverage and quality of care to people who already have insurance. The report noted that bureaucracy accounts for roughly 31 percent of health care costs in the United States, but only 16.7 percent of health care costs in Canada, which has national health insurance.

Health care spending in the United States is outstripping growth in the gross national product by 4 percent a year. In 2003, health insurance premiums increased by almost 14 percent, while the rate of inflation was closer to 2 percent. Society is redirecting dollars to health care and away from education, wages, and other benefits. Fewer people are able to afford health insurance and even people with insurance are forgoing care because out-of-pocket expenditures are too high.

A growing number of health care professional associations have endorsed health systems reforms that would lead to greater risk-pooling and would centralize claim processing and payment under a single administrative entity. In 2004, for example, the California Medical Association, said it could support a single-payer system if certain conditions could be met (billing at customary rates, coverage decisions evidence-based, multiple delivery system options, ability to purchase additional care, etc.). In 2003, more than 7,000 physicians signed on to a proposal for a single-payer health system that was outlined in the *Journal of the American Medical Association*.

The Office of the Insurance Commissioner (OIC) is currently engaged in an extensive examination of the insurance system to identify ways to reduce administrative costs. For example, it is looking at the Utah Health Information Network, which allows participants

to submit claims and other transactions through a common electronic interface. (Related efforts have been underway in Washington since 2001 under the auspices of Washington Healthcare Forum Services). One of the benefits of centralized and standardized administrative processing of claims, OIC points out, is that data can be aggregated. Larger data sets can then be used to assess the effectiveness of various interventions, creating more information for evidence-based decision making. When health data is distributed among several insurers, the data sets are often too small to be useful.

Potential Strategies

Convene a gathering of medical, insurance, government, non-profit, and business leaders to discuss ways to design an insurance system that consolidates risk pools and centralizes administrative functions. This could be something like Canada's single-payer system, or perhaps something less ambitious, like encouraging all insurance plans to use a single standardized electronic claim form and share a common claims processing entity that uses a common definition of medical necessity. Look for opportunities for consensus-building.

Criteria

Does the issue involve multiple agencies?

Yes. OIC is currently engaged in an extensive examination of the insurance system to identify ways reduce health care finance administrative costs. The Health Care Authority is the lead agency on a multi-agency effort initiated by Governor Gregoire to identify ways to control escalating health care costs (although a consultant to this effort estimates that controlling administrative costs will yield relatively low returns compared to promoting more efficient care).

Can a measurable difference be made?

Yes.

Prevalence, severity and availability of interventions

Not applicable.

Level of public input/demand

In August, the Kaiser Family Foundation (KFF) conducted a national poll about health priorities. When asked to name the most important problem for the government to address, health care ranks second (22 percent) behind war and foreign policy issues (28 percent). When asked specifically about the most important health care problem for the government to address, health care costs were mentioned by nearly 4 in 10 adults (39 percent). Access to care and insurance ranks second (23 percent, including 11 percent who name universal coverage). KFF also asked the public how important it is for the President and Congress to deal with several specific health care issues. In each case, a majority of adults say each specific issue was "very important." When asked to choose the most important issue, however, around one-quarter each say increasing the number of insured Americans (26 percent), and lowering the cost of health care and insurance (25 percent).

Does it involve the entire state?

Yes.

Does the Board have statutory authority?

The Board has broad authority to “explore ways to improve the health status of the citizenry.”

Do the resources exist to deal with the issue?

That would depend on the scope of work and goals established by the Board.

Does the Board have a potentially unique role?

Yes. As a bully pulpit with expert standing that is somewhat removed from direct political influences, it possesses a unique combination of credibility and relative independence.